OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new Title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: State of Indiana

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR 457.40(b))**

Mitchell E. Daniels, Jr., Governor, State of Indiana (Date Signed)

Submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Jeanne Maitland	Director, Care Programs
Name: Pat Casanova	Director, Office of Medicaid Policy and Planning
Name: Michael Gargano	Secretary, Indiana Family and Social Services Administration

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

TABLE OF CONTENTS

Section 1 General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2 ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3 ☒ A combination of both of the above.

- Medicaid expansion under Phase I of the CHIP program was approved June 26, 1998. State-designed child health program under Phase II of the program was approved December 22, 1999.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Original plan: Phase I - Medicaid Expansion

- Effective: October 1, 1997
- Approval: June 26, 1998
- Implementation: July 1, 1998

Amendment 1: Phase II - State Program Addition

- Submitted: September 22, 1999
- Approval: December 22, 1999
- Effective: January 1, 2000

Amendment 2: CMS Template and End Continuous Eligibility

- Submitted: September 6, 2002
- Approved: November 26, 2002
- Effective: July 1, 2002

Amendment 3: Health Services Initiative

- Submitted: August 24, 2004
- Withdrawn: May 30, 2006

Amendment 4: Premium Increase
- Submitted: October 4, 2005
- Approved: June 23, 2006
- Effective: October 1, 2005

Amendment 5: Contingency plan
- Withdrawn: October 15, 2007

Amendment 6: Income Eligibility Increase, Removal of Premium Signature Requirement, Addition of Telemedicine Services, Addition of continuous eligibility for children under age three
- Approved: January 1, 2008
- Effective: October 1, 2008

Amendment 7: Income Eligibility Increase to 300%
- Submitted: September 13, 2009
- Approved: December 3, 2009
- Effective: July 1, 2010

Amendment 8: Mental Health Expansion; CHIP Outreach Expansion; & Subspecialty Study
- Submitted: January 13, 2010
- Approved: March 16, 2010
- Effective: January 1, 2010

Amendment 9: Effective Dates
- Submitted: June 29, 2010
- Approved: February 17, 2011
- Mental Health Expansion: Effective: July 1, 2009
- 300% FPL: Effective: July 1, 2011

Amendment 10: Add Curative Care to Hospice Services
- Submitted: August 26, 2011
- Approved: February 6, 2012
- Effective: July 17, 2011

Section 2 General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a) (1)-(3)) and (Section 2105) (c) (7) (A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The table below provides information from the Kaiser State Health Facts website regarding general population characteristics. This information can be used to establish a general understanding of the current environment in the State of Indiana.

Kaiser State Health Facts (2007) for State of Indiana	
Description	**Number**
Total Children 0-18	1,685,904
Total Children 0-18 w/o Health Insurance	113,581
Total Children 0-18 Below	574,010

The table below provides information from the State of Indiana regarding the populations currently being served by Indiana Medicaid. It should be noted that MCHIP refers to the portion of the CHIP population funded via Medicaid funding and SCHIP refers to the CHIP population not funded via Medicaid funding. It should also be noted that many of the State's children are served in non-CHIP program areas. The information below can be used to establish a general understanding of the current environment in the State of Indiana.

State of Indiana (January 2009)	
Description	**Number**
Total Children 0-18 Enrolled in Medicaid	550,971
Total Children 0-18 Enrolled in Care Select	26,989
Total Children 0-18 Enrolled in Hoosier Healthwise	479,303
Total Children 0-18 Enrolled in MCHIP (Enrolled in Hoosier Healthwise)	51,008
Total Children 0-18 Enrolled in SCHIP (Enrolled in Hoosier Healthwise)	18,351

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102) (a) (2) (42CFR 457.80(b))**

Public health insurance in Indiana is provided via the Medicaid program. CHIP enrollees are enrolled in the Hoosier Healthwise program. Children eligible for the Medicaid expansion component (referred to specifically as MCHIP) are enrolled in Hoosier Healthwise under Benefit Package A. Those eligible for the State-designed component of Indiana's CHIP program (referred to as the SCHIP population) are enrolled in Hoosier Healthwise under Benefit Package C.

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child

health insurance):

Program	Purpose
Division of Family Resources (DFR) Enrollment Centers	Individuals currently apply for Hoosier Healthwise at one of more than 300 enrollment centers or through the offices of the Division of Family Resources (DFR) located in all 92 counties throughout the State. These enrollment centers can provide information on the programs under Medicaid.
Eligibility Modernization Project	Beginning October 29, 2007 the State of Indiana is modernizing its eligibility process. There is a uniform call center for questions regarding eligibility, enrollment, and Medicaid Programs.
Free and Reduced Lunch Program	Literature regarding the Medicaid program is distributed to all children that participate in the free and reduced lunch program.
Healthy Families Indiana Program	A voluntary home visitation program that makes referrals to the Hoosier Healthwise program.
Children's Special Health Care Services (CSHSC) Program	Insurance program that provides medical assistance to approximately 8,000 families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs throughout the State. CSHCS requires that children who apply for the program also apply for Medicaid.
Indiana Maternal and Child Health (MCH) Program	MCH funds 22 child or adolescent health clinics and 4 school based health clinics. Requires direct service grantees to assist clients in applying forMedicaid if they meet eligibility requirements.
Indiana Family Helpline	Provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals.
Local Health Departments	Local Health Departments (LHDs) provide immunizations, lead screenings and other direct services to individuals throughout Indiana. Some LHDs have special staff dedicated specifically to outreach activities.
Step Ahead Initiative	Designed to develop, at the local level, comprehensive seamless delivery systems for children from birth to age thirteen. The initiative is designed to support county efforts to centralize programs in order to reduce duplication and fragmentation of services.
First Steps	Indiana's early intervention system for infants and toddlers, who have developmental delays, brings together federal, state, local, and private funding sources in order to create a coordinated, community-based system of services. In each community, a "child find" system is developed and is utilized to identify, locate and evaluate children who are eligible for early intervention

	services. First Steps collaborates with the DFR by distributing information about the Hoosier Healthwise program.
Community Health Centers (CHC)	These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities and some serve as Hoosier Healthwise enrollment centers.
Indiana Minority Health Coalition (IMHC)	Used to promote healthy lifestyles through disease prevention and health awareness; and to provide referrals, information services, community outreach, and program services. The agency also collaborates with these coalitions on outreach activities for the immunization program and other programs administered by the agency. In addition, Indiana has developed statewide enrollment partnerships with Indiana Black Expo, the Wishard Hospital Hispanic Health Project and the Indiana Primary Health Care Association (IPHCA).
Consolidated Outreach Project (COP)	Provides intake assessment for migrant farm workers who enter Indiana for seasonal employment.

2.2.2. The steps the State is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Program	**Purpose**
ISDH and the IPHCA	Through a collaborative arrangement between the ISDH and the IPHCA, health care services are provided to children and other individuals throughout the State. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farm workers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers.
DMHA	The DMH has undertaken a collaborative effort with mental health providers throughout the state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and, in return, provide a full array of mental health services to seriously emotionally disturbed children who are at 200% of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the Department of Education (DOE), Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of this pilot project is to provide community-based services to children and youth in Marion County who are seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to

	the program come primarily from the Office of Family and Children, the DOE and the Juvenile Court.
Insurance Risk Pool	A partnership between the health insurance industry and the State is the underlying principle behind the financing of an insurance risk pool for medically challenged individuals who are unable to obtain traditional health insurance. The Indiana Comprehensive Health Insurance Association (ICHIA), a private non-profit association created by the Indiana General Assembly, covers adults and children. State programs make referrals to ICHIA where appropriate. ICHIA is funded through premiums, and an assessment on insurance companies licensed in the State. Since the insurance companies are able to obtain a State tax credit for these assessments, the State is an important partner in this initiative as well.

2.3. Describe the procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5)* **(Section 2102)(a)(3), 2102(c)(2) and 2102(b)(3)(E)), and (42CFR 457.80(c))**

The SCHIP program, the MCHIP Medicaid expansion, and the Title XIX Medicaid program are all closely coordinated. Individuals who apply for benefits will be considered for each of the programs. Since the CHIP program is a component of Hoosier Healthwise, the CHIP program utilizes the same delivery system as is already in place for Medicaid. The goal is to provide a medical home for each child, and to establish a seamless system of care. This ensures that the programs are coordinated not only for the benefit it provides to enrollees, but also for the purpose of administrative simplification and efficiency. For example, Family and Social Services Administration (FSSA) has modified Indiana Client Eligibility System (ICES), IndianaAIM, FSSA's cost allocation plan, and other related systems to correctly reflect expenditures eligible for reimbursement from Indiana's federal CHIP allocation.

Section 3 Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Public health insurance in Indiana is provided via the Medicaid program. CHIP enrollees are enrolled in the Hoosier Healthwise program (risk-based capitated managed care program). Children eligible for the Medicaid expansion component (referred to specifically as MCHIP) are enrolled in Hoosier Healthwise under Benefit Package A. Those eligible for the State-designed component of Indiana's CHIP program (referred to as the SCHIP population) are enrolled in Hoosier Healthwise under Benefit Package C. The Hoosier Healthwise program is governed by the Indiana Medicaid State Plan and Indiana's section 1115 demonstration. Please refer to the Indiana Medicaid State Plan and Indiana's section 1115 demonstration project for more information regarding the delivery system and structure.

Indiana will use administrative funds for a comprehensive study with the goal of developing a strategy to improve access to specialty care for low-income children.

Like many regions, northwest Indiana is struggling to provide access to care for low-income populations. The problem is particularly acute in the northwest region of Lake County, and especially with regard to access to pediatric specialty care. This has led to two sets of unacceptable outcomes. On the one hand, when children do not receive needed services, the result is avoidable hospitalizations and emergency department visits. On the other hand, when access is provided it is often through visits to out-of-state providers at a higher cost to both to the SCHIP program and to families in terms of increased travel time and inconvenience. In order to develop a strategy to increase access in this region, it is necessary to conduct a comprehensive study. Indiana has tentatively identified a partnership with Indiana University to conduct this study.

The steps in this study will include:

- *Baseline and needs assessment.* This step would involve utilizing Family and Social Services Administration and health plan data to examine access to and utilization of pediatric specialty services in the northern Lake County region compared to the rest of the state. To the greatest extent possible, public health data (including chronic disease incidence rates and ambulatory care sensitive condition admission rates specific to the region) will be utilized in this analysis.

- *Interviews with providers and other key stakeholders.* The data analysis will be supplemented with information gathered in interviews with local providers, health plans and state

officials regarding access to services. Some of the specific information gathered will be how primary care providers access specialty care for their patients, which specialties are most difficult to access, wait times for specialty appointments, and perceived barriers to improving access.

- *Identification of collaborative solutions.* The goal of the above analysis is to objectively identify issues related to neonatal and pediatric specialty access in northern Lake County. Based on this analysis, the contractor for the study will work with community providers to determine potential solutions to the issues identified. The contractor will also be expected to research and share successful models that have been implemented elsewhere.

- *Implementation assistance.* The contractor will be expected to work in an ongoing role with community providers and other key stakeholders to establish systems that will assure ongoing access to care for underserved SCHIP and other low-income children in northern Lake County.

- *Determination of need for HITECH collaboration.* The contractor will work with key stakeholders to identify the need for and interest in developing an electronic health record collaborative within the meaningful use guidelines that will support the implementation of systems that secure greater access.

The overarching goal of this initiative is to improve access, and therefore health outcomes, for children in the SCHIP program, as well as other low-income children.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Hoosier Healthwise has a number of utilization control mechanisms in place that are designed to ensure that health care use is appropriate and medically necessary.

Area	Description
Medicaid Management Information System (MMIS)	The MMIS contains a Surveillance and Utilization Review (SUR) subsystem that provides a comprehensive method for conducting utilization review and program management. Under this system, computerized reports are generated that provide a statistical profile of provider practices and recipient utilization. The system allows for the flagging of areas where there is deviation from peers. Rankings are created or identified to indicate which individuals have the greatest amount of deviation. SUR analysts take action where warranted. The objective is for misuse of health services to be identified, investigated, and corrected. Provider desk reviews are conducted based upon Federal and State requirements, and prepayment review and other action is taken where warranted. Recipient restricted card procedures are implemented in cases of recipient over utilization.
Programmatic (CHIP)	Specific mechanisms designed to prevent over utilization are also built into the Phase II CHIP program. Limitations are placed on the benefit package and nominal copayments will be imposed for certain services. A more detailed discussion regarding benefits can be found in Section 6; and a more detailed discussion regarding copayments can be found in Section 8.
Programmatic (Hoosier Healthwise)	The managed care system established under Hoosier Healthwise also has some built in utilization controls. The Primary Medical Provider (PMP), serves as a gatekeeper who provides or authorizes primary care services and makes referrals for specialty care (except those which may be self-referred) where appropriate. Referrals must be documented in the patient's medical record. In addition, MCOs are required to have written utilization review (UR) programs in place. The program must include a utilization review committee directed by the Medical Director of the MCO; utilization management practices that conform to industry standards; and resources for evaluating, and, if necessary, modifying the UR process. In order for the State to track expenditures and service utilization in the Risk Based Managed Care (RBMC) program, shadow claims are required to be reported for patient encounters. The shadow claims provide details regarding diagnoses, procedures, place of services, billed amounts and providers.

Section 4 Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan:
- Statewide

4.1.2. ☒ Age:
- 0-18 (less than 19 years of age)

4.1.3. ☒ Income:
- Children with incomes from 150-250% of the Federal Poverty Level (FPL) are eligible for SCHIP. For income amounts above 200% FPL up to 250% FPL, no standard Medicaid income deductions will be applied. Families with higher incomes will be subject to higher premiums. (A more detailed discussion on cost sharing can be found in Section 8).

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):
- Must be residents of Indiana

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage:
- Children cannot have other creditable health care coverage. A three-month waiting period from the date the child was last covered will be imposed.
- Exceptions to the waiting period will be provided if the coverage was lost involuntarily (such as through the loss of employment, divorce etc.) or if the child was previously covered by Medicaid.

4.1.8. ☒ Duration of eligibility:
- All children have 12 months as the duration of eligibility. Families are required to notify DFR if their income increases or if health insurance coverage is obtained during the eligibility period.
- Children age 3 through 18 remain eligible only as long as they meet

income and other program requirements.
- Children under age 3 receive continuous eligibility for 12 months, regardless of changes in income.
- An exception to this is allowed if an individual reports a change in income which would qualify the individual for Medicaid.

4.1.9. ☒ Other standards (identify and describe):
- To be eligible for SCHIP, families must agree to cost-sharing requirements.
- The CHIP program is also permitted to adjust eligibility requirements based upon available resources.
- Applicants must provide a Social Security Number in order to be eligible for the program, as permitted in 42 CFR 457.340.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102) (b) (1) (B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The application process and eligibility determination process for the CHIP program is integrated into the application and eligibility determination process for Hoosier Healthwise. Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. Before an application will be approved, income of a parent or guardian must be verified by supporting documentation from the payer. Acceptable items for verifying earnings include: pay stubs, statements from employers, or a wage verification form that is completed by employers. Indiana will conduct follow-up screening to identify when coverage is available through another plan. SCHIP will be discontinued beginning the day the child receives other creditable coverage.

Families who apply for benefits will be advised of the cost sharing requirements under SCHIP, and, to be considered for eligibility under SCHIP, they must agree to meet the cost-sharing requirements if the child is found eligible. In addition a conditional approval notice will be sent to the family and a record will be sent to the premium collection vendor. Once the first premium payment is made, the child becomes enrolled in the program.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b) (7)) (42CFR 457.305(b))**

☐ Check here if this section does not apply to your state.

The following procedures will be used to determine when the State might need to consider options for containing enrollment and expenditures to ensure that Indiana's budget or annual appropriation is not exceeded. This process was approved by the Children's Health Policy Board in the spring of 2000.

The CHIP office will analyze current and past MCHIP and SCHIP enrollment in order to determine future enrollment trends and projected enrollment levels. CHIP expenditures will be estimated for MCHIP and SCHIP based on previous expenditures and will monitor projected expenses to determine their impact on the budget.

Enrollment and expenditure projections will be utilized to develop an estimate of how many enrollees the State can afford to cover in CHIP and then when to consider implementing mechanisms to ensure that the budget or annual appropriation is not exceeded. Budget limitations may be the result of the state appropriation or the annual federal allocation. If either the state appropriation or the federal allocation is exceeded, the state could choose to:

Allocate additional funds from another source or limit enrollment or expenditures to remain within the original state appropriation or federal allocation by pursuing one of the following options:

- Cover SCHIP at the Medicaid match rate once Title XXI funds are exhausted
- Establish a waiting list for SCHIP
- Change the benefit package for SCHIP
- Implement cost-sharing for SCHIP to a maximum of 5% of a family's income.

The State will inform CMS if an enrollment cap is implemented.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b) (3) (A) and 2110(b) (2) (B)) (42 CFR 457.310(b) (42CFR 457.350(a) (1)) 457.80(c) (3))**

Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. The ICES system has a systematic approach to screening and enrolling an enrollee into the appropriate aid category.

Before an application will be approved, income of a parent or guardian must be verified by

supporting documentation from the payer. Acceptable items for verifying earnings include: pay stubs, statements from employers, or a wage verification form that is completed by employers. Indiana will conduct follow-up screening to identify when coverage is available through another plan. SCHIP will be discontinued beginning the day the child receives other creditable coverage. Three primary methods of third party liability policy gathering will be utilized:

- Absent parent data match using data from the State Wage Information Collection Agency
- Match with data from the Department of Defense that shows CHAMPUS coverage for dependents
- Match through Health Management Systems which matches claims information from the IndianaAIM system with insurance information from private insurance policies.
- The State will utilize the employment section of the application form to identify children who are eligible for dependent coverage under the state employees' health plan.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a) (2))**

Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. The ICES system has a systematic approach to screening and enrolling an enrollee into the appropriate aid category.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a) (1) and (2) and 2102(c) (2)) (42CFR 431.636(b) (4))**

Children who are found not eligible for Medicaid under Title XIX, are enrolled in MCHIP if they are up to 150% FPL and do not have other insurance. Title XIX, rather than Title XXI, is used to provide services for children who are under 150% FPL but who have other health insurance. The enhanced match does not apply for these children since they do not fall under the targeted low-income definition due to their other insurance coverage. Children who are above 150% but not more than 250% FPL, who do not have other health coverage and who meet the other CHIP eligibility requirements are enrolled in SCHIP if the parent/guardian agrees to the cost sharing obligation.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Indiana has instituted a number of mechanisms designed to address crowd out. To ensure that CHIP enrollees do not have other health insurance, the State requires that all CHIP recipients attest to the lack of current health care coverage

and specify the date of last coverage.

Since the MCHIP program limits family income to 150% of poverty, crowd out is not a significant issue because many of the lower income families do not have the option of employer-based health insurance.

Crowd out is of greater concern under SCHIP due to the higher income threshold. As such, Indiana has instituted three-month waiting periods and monthly premiums as crowd out deterrents under the SCHIP program. Also provisions included in Public Law 273-1999 prohibit insurers from knowingly or intentionally referring children covered under their dependent coverage policies to the CHIP program.

The Hoosier Healthwise application asks "Did any applicants who do not have health insurance lose their coverage in the last three months? Please tell us why coverage was lost." The choices are:

- Loss of employment
- Could not afford
- Coverage limit reached
- Company ended coverage
- Non-custodial parent dropped coverage
- Divorce
- Other

This information (for both approved and denied children) is entered into the ICES and monitored for signs of crowd-out among applicants. Applicants who lose coverage involuntarily are not subjected to the three-month waiting period. Denial reasons are tracked, resulting in:

- Count of applicants who were denied because they voluntarily dropped coverage but did not wait the required three months before applying
- Count of applicants who were denied because they currently carry private insurance
- Count of currently enrolled children who are denied because they gained private coverage rendering them ineligible for CHIP. This information is monitored using our aggregated data system, COGNOS.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

In addition to the above tracking procedures to monitor potential crowd out, Indiana will institute a three-month waiting period for SCHIP applicants in this income group. The only exceptions are previous coverage by Medicaid and expiration of COBRA coverage.

4.4.4.3.☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4.☐ If the state provides coverage under a premium assistance program, describe:
The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.
The minimum employer contribution
The cost-effectiveness determination

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Indiana contracts with the Indiana Minority Health Coalition (IMHC) to assure health assistance to targeted low-income children who are American Indians. The IMHC has a local Native American coalition which worked closely with the IMHC and the State of Indiana to develop culturally sensitive materials targeting a Native American audience. The State will continue to engage in collaborations with the Native American Minority Health Coalition to ensure that Native American children who are eligible for Hoosier Healthwise receive assistance. Currently, the Coordinator of the American Indian Center is available in an advisory role to the State of Indiana regarding this population.

Section 5 Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c) (1)) (42CFR 457.90)**

The outreach initiatives are listed below.

Central Office Activities:
The steps the central DFR office took are:

- Issuing a new policy directive regarding enhancing outreach and enrollment
- Analyzing the number of uninsured children per county
- Reviewing equipment specifications and technical needs so that local providers and agencies who want to partner with the State can purchase compatible equipment
- Developing a simplified shortened or joint Hoosier Healthwise application form
- Developing program outreach materials and campaigns
- Delinking Hoosier Healthwise from TANF in the computer system
- Redesigning the membership card so that no stigma is attached to carrying the card
- Creating a new training curriculum for caseworkers and other individuals
- Developing relationships with hospitals, schools, health centers and social service agencies to create enrollment centers statewide

Local Efforts:
Local DFR agency efforts include:

- Each office is given a county-specific enrollment target and are furnished a list of names of individuals and entities that they were required to contact
- Each office is responsible for working with partners in the individual communities and develop local enrollment centers
- Each office is required to develop local outreach plans geared to the specific communities.

State and Local Collaborations:
The State worked with eight community coalitions on a three year Robert Wood Johnson (RWJ) *Covering Kids* outreach grant which targeted hard to reach populations.

Public Law 273-1999 provides that the CHIP program may contract with community entities for services such as outreach and enrollment, and consumer education.

In addition to the collaborations with external coalitions, OMPP has determined that it is effective to employ local health care partners in eligibility intake efforts for the CHIP program. Toward this end, the state has contracted with Health and Hospital Corporation of Marion County (HHC), which operates Wishard Hospital, for CHIP eligibility intake services (including appropriate proportioned costs for facilities to carry out these services). These services enhance and complement other services provided by HHC, which include eligibility outstation services for both Medicaid and CHIP. HHC conducts eligibility intake to potentially eligible targeted low income children at the hospital, at other health care facilities owned by HHC, and at health fairs, schools,

and other local community organizations.

Special Populations:
The State has contracted with Black Expo, the IMHC, the Consolidated Outreach Project (migrant farmers) and the Wishard Hospital Hispanic Health Access Initiative to develop culturally sensitive materials and to implement outreach initiatives.

Section 6 Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a) (1) and 42 CFR 457.420)**

- 6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b) (1))** (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; **(Section 2103(b) (2))** (If checked, identifies the plan and attaches a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b) (3))** (If checked, identifies the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; **(Section 2103(a) (2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions. (See Attachment A, benefits package, and Attachment B, actuarial opinion memo)**

6.1.3. ☐ Existing Comprehensive State Based Coverage; **(Section 2103(a) (3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary Approved Coverage. **(Section 2103(a) (4)) (42 CFR 457.450)**

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by □existing comprehensive state-based coverage□
- 6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through

a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

For discussion of scope of services, amount, duration, exclusions and limitations, see Attachment A.

6.2.1. ☒ Inpatient services (Section 2110(a) (1))
6.2.2. ☒ Outpatient services (Section 2110(a) (2))
6.2.3. ☒ Physician services (Section 2110(a) (3))
6.2.4. ☒ Surgical services (Section 2110(a) (4))
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a) (5))
6.2.6. ☒ Prescription drugs (Section 2110(a) (6))
6.2.7. ☒ Over-the-counter medications (Section 2110(a) (7)) Coverage only applies to insulin.
6.2.8. ☒ Laboratory and radiological services (Section 2110(a) (8))
6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a) (9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a) (11)
6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a) (12))
6.2.13. ☒ Disposable medical supplies (Section 2110(a) (13)) Coverage subject to limitations.
6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a) (14))
6.2.15. ☒ Nursing care services (See instructions) (Section 2110(a) (15))
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a) (16)
6.2.17. ☒ Dental services (Section 2110(a) (17))
6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a) (18))
6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a) (19))
6.2.20. ☐ Case management services (Section 2110(a) (20)) Not Covered.
6.2.21. ☐ Care coordination services (Section 2110(a) (21)) Not Covered.
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a) (22))

6.2.23. ☒ Hospice care (Section 2110(a) (23))
6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a) (24))
6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a) (25))
6.2.26. ☒ Medical transportation (Section 2110(a) (26))
6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a) (27)) Not Covered.
6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a) (28))

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b) (1) (B) (ii))**; **OR**
6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c) (2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost-Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above. **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c) (2) (B) (i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.
Describe the cost of such coverage on an average per child

basis. (Section 2105(c) (2) (B) (ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c) (2) (B) (iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (**Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c) (3) (A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c) (3) (B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7 Quality and Appropriateness of Care

☐**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a) (7) (A)) (42CFR 457.495(a))**

External Quality Review
The State contracts with an evaluation consultant who develops and updates performance criteria, and also provides assistance in producing the evaluation and annual reports. The performance criteria are an important tool for measuring quality of care, particularly with respect to well-baby care, well-child care, and immunizations. Hoosier Healthwise uses NCQA's HEDIS measures to monitor quality.

Quality Improvement Programs
Quality assurance requirements are imposed on MCOs that contract with the State under Hoosier Healthwise. MCOs must have quality improvement (QI) programs in place that meet the federal requirements (42 CFR 438 Subpart D) and the National Committee for Quality Assurance (NCQA) standards. The QI programs must be based on annual plans that are approved by the OMPP. In addition, MCOs must meet a number of other QI requirements, including: establishing a QI Committee overseen by the MCO Medical Director; submitting Quarterly QI reports; conducting focused studies, including medical data abstraction and data entry, in areas of clinical priority for the Indiana Medicaid population; establishing internal systems for monitoring services; conducting a quality of care chart audit of providers of services; attending monthly Hoosier Healthwise Quality Improvement Committee (QIC) meetings; submitting QI data to the State; and taking other steps to improve quality of services.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

- MCOs that provide services under Hoosier Healthwise must have Quality Improvement (QI) programs in place that meet the National Committee for Quality Assurance (NCQA) standards.
- PMPs will be required to comply with universally accepted standards for preventive care, as endorsed by the American Academy of Pediatrics, the Academy of Family Physicians, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine. Specifically, these standards apply to the following areas: childhood immunizations, pregnancy, lead toxicity, comprehensive well child periodic health assessment, HIV status, asthma, diabetes, alcohol and drug abuse, sexually transmitted diseases, motor vehicle accidents, pregnancy prevention, prevention of influenza, smoking prevention and cessation, and others. Clinical practice guidelines from the Agency for Healthcare Research and Quality and the Indiana Medicaid Coordinated Care Technical

Assistance Group (TAG) may also recommend standards.

- Through the Clinical Advisory Committee, providers provide the OMPP with input on Hoosier Healthwise policies affecting quality, accessibility, appropriateness and cost effectiveness of care.
- The Hoosier Healthwise QIC oversees quality of care and appropriateness of care and integrates the quality improvement process. The Quality Integrity Committee (QIC) membership consists of MCO medical directors, MCO QI staff representatives, and the OMPP staff members
- Requests to disenroll are documented, tracked and monitored.

7.1.2. ☒ Performance measurement

- MCOs must conduct annual member satisfaction surveys, and present this information to the OMPP, recipients and providers.
- MCOs must provide the Health Plan Employer Data Information Set (HEDIS) measures to OMPP on an annual basis.
- The evaluation consultant will develop performance criteria to measure the quality of services provided under CHIP. These measures will include health status indicators and EPSDT compliance.

7.1.3. ☒ Information strategies

- Hoosier Healthwise applicants are provided with materials regarding managed care; PMPs; MCOs; preventive services; 1-800 telephone hotline; emergency room usage; grievance procedures; recipients' rights and responsibilities; coverage, cost and claims; and a summary of program activities.
- The State conducts provider training and benefit advocate training. Indiana has implemented an enhanced outreach campaign.

7.1.4. ☒ Quality improvement strategies

- The State has a toll free telephone number for recipients and providers. Staff investigates inquires and complaints received through this phone line.
- The Hoosier Healthwise MCOs monitor PMPs 24-hour accessibility by making random calls to PMPs during regular business hours and after hours.
- The State monitors several key indicators to assure that access problems do not arise. These indicators include: waiting periods; access to care after hours; referrals to specialists; and access to emergency or family planning services.
- MCOs must conduct focus studies on areas of clinical priority including preventive care, behavioral health, prenatal outcomes, and disease management (e.g. asthma and diabetes care).

7.2. Describe the methods used, including monitoring, to assure: **(2102(a) (7) (B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a) (7)) (42CFR 457.495(a))**

- The State employs an External Quality Review Organization (EQRO) that monitors and assesses the quality of and access to health care enabled by Hoosier Healthwise. Advising the monitoring process is a Quality Improvement Committee, a Clinical Advisory Committee, and Focused Study Workgroups. The Focused Study Workgroups include neonatal outcomes, management of members with complex needs, and behavioral health. The HEDIS is being utilized for tracking health plan performance on an annual basis. Several quarterly reports based on HEDIS specifications are also provided to OMPP by the Hoosier Healthwise MCOs. The State's EQRO is also the CHIP's independent evaluation consultant. Data collected by the vendor for the EQR are refined for the purpose of assessing CHIP's programmatic effectiveness in this area.
- CHIP monitors the size of Primary Physician panels monthly.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a) (7)) 42CFR 457.495(b))**

The evaluation consultant is responsible for updating and developing tools to measure the utilization of health services. The measure set will be intended to assess how often, how effectively and how appropriately enrollees are utilizing services under the program.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a) (7)) (42CFR 457.495(c))**

All Hoosier Healthwise members are allowed to select a Primary Medical Provider. If one is not selected within 30 days, a PMP will be assigned to them. By ensuring that all members have a medical home, chronic, complex, or serious medical conditions can be closely monitored and appropriate referrals can be made when necessary. In addition, when the network is not adequate for the enrollee's medical condition, managed care organizations are required to allow members to access to out-of-network providers.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a) (7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are completed in accordance with the CHIP administrative rules, found in Title 407 of the Indiana Administrative Code, Section 3-3-2:

"The procedures and requirements set forth in 405 IAC 5-3 and 405 IAC 5-7 for Medicaid prior authorization, administrative review, and appeals shall apply to the Children's Health Insurance Program." This authority is granted by IC 12-17.6-2-11.

Section 8 Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. ☐ NO, **skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e) (1) (A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a) &(c))

8.2.1. **Premiums:**

Sliding scale premiums (see chart below) will be imposed on families of children eligible for the Title XXI SCHIP program. Cost-sharing for these families (with incomes above 150% of FPL), will not exceed five percent of the family's yearly income. Individuals eligible under MCHIP (with incomes up to 150% of FPL) will continue to comply with cost-sharing limitations established under Medicaid. SCHIP individuals pay premiums monthly.

If an applicant is determined to be eligible for SCHIP (Hoosier Healthwise Package C), ICES issues a notice to the applicant informing him or her of the premium payment responsibility for enrollment, and holds the account in suspense. Information regarding the eligibility status and cost-sharing responsibilities is transferred to the premium-collection vendor. The premium-collection vendor issues a premium statement and provides detailed information regarding the cost-sharing requirements. If the premium is paid by the due date, the premium-collection vendor transfers this information to ICES and the applicant's account is changed from suspended status to enrolled. The applicant becomes retroactively eligible for SCHIP coverage beginning the first day of the month the application was submitted to the DFR.

If the premium is not paid by the due date (the 12th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program. Families that have been disenrolled due to non-payment of premiums may re-apply for coverage immediately. After meeting eligibility requirements, including the payment of all delinquent and current premiums due, the disenrolled child (ren) may be re-enrolled in the program.

PREMIUMS

Income (As a percent of FPL)	One Child	Two or More Children
Over 150 to 175 percent	$22.00	$33.00
Over 175 to 200 percent	$33.00	$50.00
Over 200 to 225 percent	$42.00	$53.00
Over 225 to 250 percent	$53.00	$70.00

8.2.2. Deductibles:

Not Applicable.

8.2.3. Coinsurance or copayments:

Copayments for certain services will be imposed under the SCHIP program. (See chart below). These copayments will be established primarily as a utilization control mechanism. Providers will be responsible for collecting these nominal copayments.

COPAYMENTS

Service	Copayment
Prescription Drugs — Generic, Compound and Sole-Source	$3
Prescription Drugs — Brand Name	$10
Emergency Ambulance Transportation	$10

8.2.4. Other:
None

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e) ((1) (B)) (42CFR 457.505(b))**

A number of methods have been used to inform the public about cost-sharing requirements and any changes to them under CHIP. These include:

- Notice in the Hoosier Healthwise brochure;
- Notice in the application form (if the family does not agree to the cost-sharing requirements under SCHIP, the child will be considered only for Medicaid or MCHIP and will not be considered for SCHIP);
- Notice in the conditional approval form which is sent to the family after the child is found conditionally eligible for SCHIP before the family has received the premium notice;
- Notice in the first premium voucher which is sent to the family by the premium collection

vendor;
- Notice in the members' handbooks which are sent once the first premium has been paid and the child has been enrolled;
- Public hearings are held regarding state statute rule changes including those defining cost sharing requirements;
- Publication in the Indiana Register; and
- Publication in the Indiana Administrative Code.
- Enrollees are sent a notice generated from the eligibility system that informs them of their cost-sharing maximum

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e) (1) (B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e) (2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e) (1) (A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e) (3) (B)) (42CFR 457.560(b) and 457.505(e))**

Indiana will utilize a "shoe box" approach, similar to that used by the Massachusetts CHIP program.

In an enrollment notice, automatically generated from the eligibility system, families are informed of their cost sharing limit based on their individual income, and instructed to keep records of their payments. They are further instructed to contact the Hoosier Healthwise Package C payment line for instructions about future payments if they believe their premium plus co-payments (if applicable) have reached the amount on the enrollment notice.

To ensure that no eligible children are charged cost sharing in excess of the cumulative cost-sharing maximum the office will obtain monthly reports from ICES that will reflect cost-sharing limits at the case level. Monthly, these reports will be compared to premium payment reports provided by the premium collection vendor. We will monitor MCOs for co-payment activity to confirm none are made or to track amounts per enrollee. Using this information the office will be able to determine which enrollees are within range, yet under the cost-sharing maximum. Those enrollees who have accumulated premium payment and co-payment liability within 4% of their annual income will be notified of their status and advised to stop premium payments and co pays, and to submit their records for review and confirmation of non-payment status. After payment record review and non-payment status confirmation, the office will notify:

a) The premium vendor to waive premiums/suspend invoicing through the remainder of the benefit period, and
b) The MCO (who will then notify their pharmacy and ambulance transportation vendors) to waive co-payments through the specified date.

A letter will be sent to each family who meets their 5% cap that may be used to confirm their cost-share-free status to vendors as needed with instructions to the vendor on how to verify

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b) (3) (D)) (42CFR 457.535)**

Targeted low-income children of American Indian and Alaskan Native families are excluded from the cost-sharing requirements. The ICES system has been modified to allow a manual system override procedure to exempt these individuals from cost-sharing once they have been deemed eligible.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

If the premium is not paid by the due date (the 12th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program.

In both situations above, the applicant or enrollee will receive an ICES notice that provides for appeal of the closure or denial decision. The notice states in part:

"You have the right to appeal and have a fair hearing. An appeal will be accepted if it is received within 30 days of this notice or within 30 days of the effective date of the action,, whichever is later. We will allow 3 extra days for mailing.

If you wish to appeal, send a signed letter to your local Division of Family Resources office at the address at the top of this Notice. If you prefer, you can send your appeal to the Indiana Family and Social Services Administration, Division of Family Resources, Hearings and Appeals, room W392, Indianapolis IN 46204. If you have questions, please contact your caseworker.

You will be notified in writing of the date, time and place for the hearing. You can represent yourself, or have someone represent you such as attorney, friend, or relative. If your wish to have legal representation and cannot afford it, you may call the Legal Services Organization serving your area at (800) 892-2776."

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c) (4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c) (5) (42CFR 457.224)** *(Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c) (6) (A)) (42CFR 457.626(a) (1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d) (1)) (42CFR 457.622(b) (5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))** (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9 Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

See Chart below.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

See Chart below.

9.1 Strategic Objective	9.2 Performance Goal	9.3 Objective Means of Measuring Performance
9.1.1 Reduce Uninsured Previously uninsured low-income children will have health insurance through Indiana's Title XXI program	Maintain state's uninsured rate for population at or below 200% FPL below the 25th percentile of states nationally	US Census CPS 3 year average uninsured rate for children under age 19 at or below 200% FPL
9.1.2 Enrollment Targeted low-income children will have health insurance through Indiana's Title XXI program	Enrollment of approximately 13,500 children between 200% and 250% FPL by 9/30/2012	Hoosier Healthwise enrollment in the 200-250% FPL bracket
9.1.3 Access to Care Children enrolled in Indiana's Title XXI Program will have access to appropriate behavioral health care	The rate at which children prescribed ADHD medication will have the appropriate follow up visits with a behavioral health provider will exceed the HEDIS 50th percentile for Medicaid	HEDIS measure for follow up care for ADHD medications (ADD), initiation phase
9.1.4 Preventive Care Immunizations-children will receive the recommended immunizations	The rate at which children receive immunizations will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS Report Submission (July of each year)	HEDIS (CIS), Combo Three
9.1.5 Adolescent Well Care Adolescents aged 12-21 will receive recommended well care visits	The rate at which adolescents aged 12-21 will receive the recommended well care visits will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS report submission (July of each year)	HEDIS (AWS) for ages 12-21 years
9.1.6 Well-Child Visits First 15 months of life, six or	The rate at which children 0-15 months of age receive at least	HEDIS (W15) for children ages 0-15 months

more visits.	six well care visits will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS report submission (July of each year).	
9.1.7 Well-Child Visits, ages 3-6 years	The rate at which children 3-6 years of age receive at least one preventive exam will exceed the HEDIS 50th percentile at the time of HEDIS report submission (July of each year.	HEDIS (W34) for children 3-6 years of age

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a) (4) (A), (B)) (42CFR 457.710(d))

See Chart above.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a) (4))**

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☒ Other child appropriate measurement set. List or describe the set used. Milliman EBM for adolescengs aged 7-11, similar to HEDIS measures for other age ranges, to fill the age gap not included in HEDIS measurement set.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b) (1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b) (2)) (42CFR 457.750)**

The State assures that it will submit the evaluation required under Section 10 by January 1st of each year. The State also assures that it will complete an annual assessment of the progress made in reducing the number of uncovered low-income children, and report to the Secretary on the result of the assessment.

The assessments will be based largely upon the strategic objectives set forth in Section 9 and program evaluation criteria designed by the evaluation consultant. The strategic objectives focus on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, and improving health status. The data used to measure performance and assess the quality of care provided to Hoosier Healthwise children will be compiled from existing databases and the audited health plan-reported HEDIS results for child-relevant measures.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b) (3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a) (4) (C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

Public Input on Plan Design:
In designing the first and second phases of the CHIP program, Indiana developed a public input plan that included several different levels of discussion, and which capitalized on the expertise

and experience of a myriad of individuals and entities within the state. This input included:

- A twenty-one member bi-partisan Governor's Advisory Panel representing a cross-section of Indiana experts was appointed to develop a blueprint on implementation of the CHIP program. Members on the panel included: hospital representatives, physicians, insurance executives, parents, advocates, school officials, health clinic representatives, and members of the Indiana General Assembly. Numerous press releases were utilized to publicize the work of the Advisory Panel. All meetings were publicized and covered by the news media. Further, there was significant news coverage during the General Assembly's deliberations on the Governor's CHIP proposal.
- Five subcommittees were established to provide a broader range of input and allow for in-depth discussion and analysis on key areas of importance. Membership on the subcommittees included: hospitals, physicians, nurses, pharmacists, local health department representatives, optometrists, mental health providers, economists, academics, numerous community and social services programs, migrant farmworkers and homeless parents, and various other experts. The subcommittees focused on the following key topics: Coordination/Infrastructure/Provider Supply/Community Systems; Benefits and Cost Sharing; Eligibility and Crowd Out; Outreach and Education; and Data, Evaluation and Outcomes. The subcommittees' reports were submitted to the Advisory Panel for consideration.
- A series of eight public forums were held across the state in order to allow for a wide range of input from individuals and entities within individual communities. The forums provided opportunities for citizens to share their concerns regarding methods for improving and for building upon the state's current health care system, and mechanisms for encouraging parents to access health services. In order to maximize awareness and participation, the forums were held at a number of different sites and at varying times. The local social service and health promotion agencies helped select the most appropriate time and location for each hearing. To promote the forums, the organizers worked closely with numerous individuals and entities. Assistance was provided by the local WIC sites, local Maternal and Child Health (MCH) agencies, local immunization sites, local Medicaid providers, community health centers, local DFR offices, the LHDs, and the Indiana Coalition on Housing and Homeless Issues. In order to make it easier for parents to attend, child care was provided during the forums. Individuals who were not able to attend were encouraged to submit written comments. State and local news media were notified in advance of all public forums through a myriad of sources. News releases, media advisories and telephone calls were all utilized in an effort to maximize press coverage.
- Numerous focus groups were established to draw upon the expertise, experience, and perspectives of homogeneous groups of individuals. The focus groups consisted of groups of providers, advocates, parents and adolescents. The groups met in various locations throughout the State and discussed key issues from their own specific perspectives.
- The Phase II benefits package was sent to stakeholders with requests for comments.
- Discussion of plan design was also possible during the rulemaking process. A public hearing was held during this process.
- As part of its CHIP oversight responsibility, the Policy Board established broad based committees in the areas of: children with special health care needs, data, and program coordination.

- Legislative oversight of the CHIP program will be provided by the Select Joint Committee on Medicaid Oversight.

Promotion of Plan Implementation:
The Chair of the Governor's Advisory Panel appeared before various editorial boards as a means of increasing awareness of the CHIP program. A CHIP website was developed to provide information regarding the CHIP program. This website (http://www.in.gov/fssa/ompp/2545.htm) is updated regularly and also includes a link to the Hoosier Healthwise website for families. Radio and television public service announcements were aired throughout the State. A radio blitz that included information about Hoosier Healthwise in a "Back to School" message was run throughout the State. Billboards, bus placards, and newspaper ads have also been used to promote the program. And, with the assistance of local DFR offices, local newspapers have run articles informing families about Hoosier Healthwise.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Indiana contracted with the Indiana Minority Health Coalition (IMHC) and Wishard Hispanic Health Project during the design, implementation, and early stages of the CHIP program to develop culturally sensitive materials targeting a Native American audience and to assure that Native American children who are eligible for the program received assistance. Currently, the Coordinator of the American Indian Center is available in an advisory role to the State regarding this population.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65 (b) through (d).

In the 2002 Indiana legislative session, state law (P.L. 107-2002) was passed to eliminate continuous eligibility from Hoosier Healthwise. As a result, it was necessary to amend our MCHIP administrative rules. As required by Indiana's rulemaking statute (IC 4-22-2), the agency provided public notice of the change before the rule was adopted. The proposed rule was published in the Indiana Register on June 1, 2002. Notice of the public hearing concerning the proposed change was published in the Indianapolis Star newspaper on May 24, 2002. A public hearing was held June 24, 2002. The agency complied with the public notice requirements prior to the July 1, 2002 effective date of the change in eligibility.

In addition to the public notice required by the rulemaking process, the agency provided notice of the change to all Hoosier Healthwise members. All Hoosier Healthwise members were sent a notice between June 17, 2002 and June 21, 2002 advising them of the change in law and how it would affect them. In addition, the CHIP premium collection vendor also sent flyers out with members' invoices in order to provide them with an additional reminder of the change in eligibility. These flyers were included with the June, July, and August 2002 invoices.

In the 2007 Indiana legislative session, state law (P.L. 218-2007) was passed to increase the income eligibility up to 250% FPL, and create continuous eligibility for children until three (3) years of age. The statute gives authority to the Office of Medicaid Policy and Planning to adjust eligibility based on available program resources and further gives rulemaking authority to establish premiums. The rulemaking process with all notice and comment requirements will be followed as described above.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including –
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Estimated Fiscal Impact of Amendment #10

CURRENT AND PROJECTED SCHIP - PACKAGE A & C EXPENDITURES				
CHIP AMENDMENT #10				
	FY2011		**FY2012**	
Actual/Projected Expenditures (S/F)	141,068,268		148,121,682	
Less:				
300% FPL	-		-	
Subtotal	-		-	
Total Projection up to 250% to FPL	141,068268		148,121,682	
Add:				
300% FPL Addition of curative care concurrent with hospice services	-		12,000	
Subtotal	-		12,000 -	
Total	141,068,268		148,133,682	

Administration Costs	**2011**		**2012**	
Personnel	1,677,699		1,000,000	[2]
General Administration	26,045		26,045	
Contractors/Brokers (enrollment contractors)	1,184,428		1,500,000	
Claims Processing	2,097,537		2,097,537	
Outreach/Marketing Costs			2,225,000	
Other (e.g. indirect Costs)	17,695		500,000	
Health Services Initiatives				
Total Administration Costs	5,003,404.		7,348,583	
10% Administrative Cap (net benefits /9)	15,674,252		16,459,298	
Total Program Cost	141,068,268		148,133.682	
State Share	33,066,402	23.44%	34,263,321	23.13%
Federal Share	108,001,866	76.56%	113,870,361	76.87%
[1]The State has opted not to implement the 300% FPL expansion at this time				
[2]Indirect costs related to Cost allocation from sister divisions under the FSSA Agency umbrella..				

Funding Source:
The state portion of the expenditures will be generated from the State's tobacco settlement money. State general revenues will be used as a supplement, if needed.

Section 10 Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a) (1), (2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11 Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12 Applicant and Enrollee Protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters and Health Services Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

See section 12.2.

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

The Division of Family Resources is responsible for determining eligibility for the aid categories that provide medical assistance through CHIP. The DFR has a comprehensive hearings and appeals process in place for all public assistance programs, including Medicaid and CHIP. The following is their policy on the review process for both eligibility and medical assistance matters.

All individuals must be informed in writing at the time of application and when action is taken which affects their benefits, of: the right to a fair hearing; and the method for requesting a hearing. This information is contained in the Rights and Responsibilities listing which is given to applicants, and is also on all eligibility notices. The freedom to make such a request must not be limited or interfered with in any way.

The Local DFR Office is responsible for assisting a dissatisfied applicant so that they may fully exercise their right to appeal. Any time an individual expresses a disagreement with any action taken, they must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual who is having difficulty in preparing the written request for an appeal. The individual is to be informed that they may represent themselves at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of their choice. Information and referral services should also be provided to help the dissatisfied applicant make use of any free legal services that are available in the community.

Any action with which an applicant/recipient is dissatisfied may be appealed. An applicant may appeal and have a fair hearing when his application for financial or medical assistance is denied or not acted upon with reasonable promptness. A recipient may appeal when they believe the Local Office has taken erroneous action to reduce, suspend or discontinue assistance. In addition, a recipient or provider of medical services may appeal an action to deny or limit services under the Medicaid program.

Below is the language found on all CHIP eligibility notice:

"You have the right to appeal and have a fair hearing. An appeal will be accepted if it is received within 30 days of this notice, or within 30 days of the effective date of the action, whichever is later. We will allow 3 extra days for mailing.

If you wish to appeal, send a signed letter to your local Division of Family Resources office at the address at the top of this Notice. If you prefer, you can send your appeal to the Indiana Family and Social Services Administration, Division of Family Resources, Hearings and Appeals, room W392, Indianapolis IN 46204. If you have questions, please contact your caseworker.

You will be notified in writing of the date, time and place for the hearing. You can represent yourself, or have someone represent you such as attorney, friend, or relative. If your wish to have legal representation and cannot afford it, you may call the Legal Services Organization serving your area at (800)892-2776."

FSSA requires an expedited review process for medical services when requested by the enrolled member in certain situations. Each MCO is contractually required to "make available an expedited informal and formal grievance procedure for member grievances that cannot be delayed without risking permanent damage to the member's health," and the expedited review must be completed within 72 hours. Members are notified by their MCO. Each MCO has a member handbook that gives guidance on this issue. For example, the MDwise MCO member handbook states: "In an emergency, grievances will be handled quickly. This is called an "expedited" grievance or appeal. If your case can be expedited, we will review your case and notify you of a decision within 72 hours. Call us at (317) 630-2831 or 1-800-356-1204 to see if this can be done." The review process is in compliance with Indiana's health insurance law, I.C. 27-13-10.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Service	Hoosier Healthwise Package A Benefits	Hoosier Healthwise Package C Benefits
Inpatient Hospital Services*+	Inpatient/outpatient services covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the condition. Does not include services that are not medically or clinically reasonable or necessary; post-stabilization services that are not prior authorized; experimental services; personal comfort or convenience items; services for remediation of learning disabilities; amphetamines when prescribed for weight control; fallopian tuboplasty for infertility or vasovasostomy; air fluidized suspension type hospital beds; cybex services; autopsy; cryosurgery for chloasma; conray dye injection supervision; day care or partial day care or partial hospitalization; pulmonary exercises and rehabilitation programs; cognitive rehabilitation; telephone consultation; non-legend stop smoking aids; artificial insemination; private duty nursing.	Inpatient and outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Coverage is subject to the same limitations as Medicaid.
Outpatient Hospital Services*+	Inpatient/outpatient services covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the condition. Does not include services that are not medically or clinically reasonable or necessary; post-stabilization services that are not prior authorized; experimental services; personal comfort or convenience items; services for remediation of learning disabilities; amphetamines when prescribed for weight control; fallopian tuboplasty for infertility or vasovasostomy; air fluidized suspension type hospital beds; cybex services; autopsy; cryosurgery for chloasma; conray dye injection supervision; day care or partial day care or partial hospitalization; pulmonary exercises and rehabilitation programs; cognitive rehabilitation; telephone consultation; non-legend stop smoking aids; artificial insemination; private duty nursing.	Inpatient and outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Coverage is subject to the same limitations as Medicaid.
Rural Health Clinics	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.
Federally Qualified Health Centers (FQHCs)	Reimbursement available for medically necessary services provided by licensed health care practitioners.	Reimbursement available for medically necessary services provided by licensed health care practitioners.
Laboratory and Radiology Services+	Must be ordered by a physician.	Must be ordered by a physician.
Nurse Practitioners	Reimbursement is available for medically necessary services or preventative health services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Reimbursement is available for medically necessary services or preventative health services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Early Intervention Services+	The Indiana EPSDT program includes initial and periodic screenings, and treatment services in accordance with the HealthWatch EPSDT periodicity and screening schedule. Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services.	Covers immunizations, and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the CHIP benefit package coverage limitations.
Family planning services	Provided with limitations.	Provided with limitations.

** = Prior Authorization is Always Required
* = Prior Authorization is required under certain circumstances
= Federally Required CHIP Benefit

Physicians' surgical and medical services*+	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Prior approval required for services not provided directly my M.D. or D.O. Will not reimburse for preparation of reports; missed appointments; writing or telephoning prescriptions to pharmacies; telephone calls to laboratories; after-hours services. PMP office visits limited to a maximum of 30 per year per recipient without prior authorization.	Covers reasonable services provided by M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Prior approval required for services not provided directly by a M.D. or D.O. Will not reimburse for preparation of reports; missed appointments; writing or telephoning prescriptions to pharmacies; telephone calls to laboratories; after-hours services. PMP office visits limited to a maximum of 30 per year per recipient without prior authorization.
Nurse-midwife services	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Podiatrists	No more than 6 routine foot care visits per year are covered.	Surgical procedures involving foot, laboratory/x-ray services, and hospital stays are covered when medically necessary. Coverage is subject to the same limitations as Medicaid.
Optometrists+	Reimbursement for the initial vision care examination will be limited to one (1) examination per year for a recipient under nineteen (19) years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.	Reimbursement for the initial vision care examination will be limited to one (1) examination per year for a recipient under nineteen (19) years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.
Eyeglasses+	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year except when a specified minimum prescription change makes additional coverage medically necessary. Repairs or replacements of eyeglasses will be reimbursed only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or automobile accident. Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars ($20) per pair except when medical necessity requires a more expensive frame. Contact lenses are covered only when medically necessary and are not covered for cosmetic purposes.	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year except when a specified minimum prescription change makes additional coverage medically necessary. Repairs or replacements of eyeglasses will be reimbursed only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or automobile accident. Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars ($20) per pair except when medical necessity requires a more expensive frame. Contact lenses are covered only when medically necessary and are not covered for cosmetic purposes.
Chiropractors*	Reimbursement is available for covered services provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic. Limited to 5 visits and 50 therapeutic physical medicine treatments per recipient per year.	Reimbursement is available for covered services provided by a licensed chiropractor, enrolled as Indiana Medicaid provider, when rendered within the scope of the practice. Limited to 5 visits and 14 therapeutic physical medicine treatments per recipient per year. Additional treatments will be covered if medically necessary and approved prior.
Home Health Services**	Reimbursement is available to home health agencies for skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis. Provided with limitations.	Reimbursement is available to home health agencies for skilled nursing services provided by registered nurse or licensed practical nurse; home health aide services; physical, occupational, respiratory therapy services; speech pathology services; and renal dialysis. Provided with limitations.

** = Prior Authorization is Always Required
* = Prior Authorization is required under certain circumstances
= Federally Required CHIP Benefit

Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)**	Medicaid reimbursement is available for medical supplies, equipment, and appliances suitable for use in the home. Coverage does not include equipment that basically serves comfort or convenience functions; physical fitness equipment; first aid or precautionary type equipment; self-help devices; training equipment; cosmetic equipment; adaptive or special equipment; air fluidized suspension beds; supportive foot devices or orthotics for the foot; motorized vehicles are covered only when the recipient is enrolled in a school, sheltered workshop, or work setting, or if the recipient is left alone for significant periods of time.	
Dental Services	Covers sealants, restorations and pulp caps. Either full mouth series radiographs or panorex is limited to one set per recipient every three years; bitewing, intra-oral, and extra-oral radiographs are limited to one set per recipient every twelve months; one comprehensive or detailed oral evaluation per lifetime; one periodic evaluation every six months; study models are not covered; mouth gum cultures and sensitivity tests are not covered; one topical application of fluoride every six months for patients eighteen months of age or older but younger than nineteen; periodontal root planning and scaling for recipients over three years of age and under twenty-one is limited to four units every two years; infection control not covered; palliative treatment of facial pain is limited to emergency treatment only; payment for office visits is not covered. In accordance with Federal law, all medically necessary dental services are provided for children under age twenty-one even if the service is not otherwise covered under the State Plan.	Covers sealants, restorations and pulp caps. Either full mouth series radiographs or panorex is limited to one set per recipient every three years; bitewing, intra-oral, and extra-oral radiographs are limited to one set per recipient every twelve months; one comprehensive or detailed oral evaluation per lifetime; one periodic evaluation every six months; study models are not covered; mouth gum cultures and sensitivity tests are not covered; one topical application of fluoride every six months for patients eighteen months of age or older but younger than nineteen; periodontal root planning and scaling for recipients over three years of age and under twenty-one is limited to four units every two years; infection control not covered; palliative treatment of facial pain is limited to emergency treatment only; payment for office visits is not covered. Like Medicaid, all medically necessary dental services are provided for CHIP children even if the service is not otherwise covered under CHIP.
Physical Therapy**	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Covered for no longer than 2 years. No more than 1 hour per day per type of therapy. Not to exceed twelve hours per 30 calendar days.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.
Speech, Hearing and Language Disorders*	Prior authorization not required for initial evaluations. Evaluations and reevaluations limited to three hours of service per evaluation.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.
Occupational Therapy**	Must be performed by registered occupational therapist or assistant under direct supervision. Evaluations and reevaluations limited to three hours of service per evaluation. May continue for a period not to exceed twelve hours in thirty calendar days.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.
Respiratory therapy*	Prior authorization not required for inpatient or outpatient hospital, emergency, oxygen in nursing facility, thirty days following discharge from hospital when ordered by physician prior to discharge.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.
Prescribed (Legend) Drugs+	Agents to promote weight loss, topical monoxidil, fertility enhancement drugs, and drugs for cosmetic purposes not covered.	Agents to promote weight loss, topical monoxidil, fertility enhancement drugs, and drugs for cosmetic purposes not covered. Insulin, a non-legend drug, will also be covered.
Inpatient Rehabilitative Services**	Prior authorization is required. Educational services not covered.	Prior authorization is required. Educational services not covered.

** = Prior Authorization is Always Required
* = Prior Authorization is required under certain circumstances
= Federally Required CHIP Benefit

Outpatient mental health/substance abuse services+	Includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Office visits limited to a maximum of 20 per year per recipient without prior approval. Covers Medicaid Rehabilitation Option (MRO) services.	Includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Office visits limited to a maximum of 20 per year per recipient without prior approval. Covers Medicaid Rehabilitation Option (MRO) services.
Inpatient mental health/substance abuse services**+	Each patient admitted must have an individually developed plan of care developed by the physician and interdisciplinary team. Plan of care must be reviewed and updated every thirty days by the interdisciplinary team. Recertification is required every 60 days. Covers inpatient mental health and substance abuse services when provided in an institution with more than 16 beds (recipients under 21 years of age and over 65 years of age) and psychiatric residential treatment services (recipients under 21 years of age).	Each patient admitted must have an individually developed plan of care developed by the physician and interdisciplinary team. Plan of care must be reviewed and updated every thirty days by the interdisciplinary team. Recertification is required every 60 days. Covers inpatient mental health and substance abuse services when provided in an institution with more than 16 beds (recipients under 21 years of age and over 65 years of age) and psychiatric residential treatment services (recipients under 21 years of age).
Hospice care (available with or without curative care)**	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.
Ambulance Transportation*	No limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge.	Covers ambulance transportation. Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician.
Diabetes Self Management Training*	Limited to 16 units per recipient per year. Additional units may be prior authorized.	Limited to 16 units per recipient per year. Additional units may be prior authorized.
Out-of-state Medical Services**	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies.	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.
Orthodontics	When medically necessary.	When medically necessary.
Food Supplements, Nutritional Supplements, and Infant Formulas**	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.

** = Prior Authorization is Always Required
* = Prior Authorization is required under certain circumstances
= Federally Required CHIP Benefit